Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KRANTI PURIMELTA, MD
3100 TIMMONS LN STE 250
HOUSTON, TX 77027

Respondent Name

TEXAS HOSPITAL INSURANCE EXCHANGE

Carrier's Austin Representative Box

Box Number 06

MFDR Tracking Number

M4-12-0997-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION HAS BEEN SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Documentation in the records do not indicate there is a question of compensability by the claimant, treating physician or the adjuster. Therefore the additional MMI/IR rating was not required and is not payable."

Response Submitted by: IMO, Injury Management Organization, Inc., 4100 Midway Road, Ste 1145, Carrollton, Texas 75007

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2011	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes: Explanation of benefits dated August 25, 2011

- Charge exceeds Fee Schedule allowance
- W1 – Workers Compensation State Fee Schedule Adjustment.
- Notes – MMI 11/22/10 IR 0% 2 BODY AREAS

Explanation of benefits dated September 15, 2011

- 193 – Original payment decision is being maintained. Upon review, it was determined this claim was processed properly
- W1 – Workers Compensation State Fee Schedule Adjustment
- Notes – DD/CLINICAL MMI/0% IR/ROM (BACK. RT SHOULDER)

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed the amount of $950.00 for CPT code 99456-WP-W5 for Division ordered DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The narrative documentation supports the rating of the right shoulder and left wrist (upper extremity) with the Range of Motion (ROM) IR method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and a MAR of $300.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic are part of one body area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on the lumbar, thoracic and cervical (spinal region) is $150.00. There was no request for IR testing or examination for the knee (lower extremity) on the DWC-32, nor was there any dispute as to extent of injury to justify the rating and reimbursement. MMI/IR MAR is $800.00.
2. Respondent has paid $800.00 on CPT code 99456-W5-WP and no additional amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 28, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.